Nancy B.: the Criminal Code and decisions to forgo life-sustaining treatment

Arthur Fish, LLB, BCL; Peter A. Singer, MD, MPH, FRCPC, FACP

Nancy B. was a 25-year-old woman who had had generalized polyneuropathy for 2½ years as a result of Guillain–Barré disease. Her motor paralysis made her dependent on a respirator, and her condition was not expected to improve. She had persistently requested that her respirator be withdrawn. A psychiatrist who had examined her four times found her to be competent to make medical decisions; however, the hospital in which she was a patient refused to permit the respirator to be disconnected. Nancy B. initiated a legal action for an injunction permitting her physician to withdraw the respirator. Mr. Justice Dufour of the Quebec Superior Court granted the injunction. Nancy B.'s respirator was withdrawn, and she died on Feb. 13, 1992.[1]

Mr. Justice Dufour had to decide first whether the civil law[2] permitted Nancy B. to refuse life-sustaining treatment and then whether the criminal law did. He concluded that the "logical corollary of [the] doctrine of informed consent is that the patient generally has the right not to consent, that is the right to refuse treatment and to ask that it cease where it has already been begun." Furthermore, this right encompasses the informed and freely given refusal of life-sustaining treatment, such as the use of a respirator.[3] This holding accords with case law and with the weight of academic and professional opinion.[4-10] More noteworthy, however, is the judge's conclusion that certain provisions of the Criminal Code that seem to prohibit the withholding or withdrawal of life-sustaining treatment do not actually do so.[11-13] This judicial decision is probably the first in Canada on this point and for that reason alone worthy of consideration. Unfortunately, the case of Nancy B. does not finally resolve the conflict between the realities of contemporary medical practice and the criminal law and so highlights the need for amendments to the Criminal Code.

The problem for physicians is that by withholding or withdrawing life-sustaining treatments, such as cardiopulmonary resuscitation and the use of respirators and feeding tubes, they may in theory have committed a crime. Although there appear to be no reported cases of such prosecutions brought against physicians the risk remains. In this article we review the Criminal Code provisions relevant to the withholding or withdrawal of life-sustaining treatment, critique Mr. Justice Dufour's interpretation of these provisions in the Nancy B. case and propose amendments that explicitly exclude the appropriate withholding or withdrawal of life-sustaining treatment from the criminal law. Our amendments could be adopted as guidelines by provincial attorneys-general who wish to eliminate the risk of criminal charges for physicians who appropriately withhold or withdraw life-sustaining treatment.

Criminal law and life-sustaining treatment

To explain Mr. Justice Dufour's reasoning in the Nancy B. case we must review some provisions of

Mr. Fish is a doctoral candidate in the Faculty of Law, University of Toronto, and Dr. Singer is assistant professor of medicine and associate director, Centre for Bioethics, University of Toronto, Toronto, Ont.

Mr. Fish holds a University of Toronto open fellowship. Dr. Singer is supported in part by a medical scholarship from the Canadian Life and Health Insurance Association and a George Morris Piersol Teaching and Research Scholarship from the American College of Physicians. The Centre for Bioethics is supported by grant 03006 from the Ontario Ministry of Health and by the Bertha Rosenstadt and William C. Harris estates. The views expressed are the authors and do not represent those of the sponsoring groups.

Reprint requests to: Dr. Peter A. Singer, Centre for Bioethics, University of Toronto, Rm. 303, Tanz Neuroscience Building, 6 Queen's Park Cres. W, Toronto, ON M5S 1A8

← For prescribing information see page 758

the Criminal Code, including those governing murder and manslaughter,[14] criminal negligence,[15] counselling, aiding or abetting a person to commit suicide,[16] and consent to the infliction of death.[17]

Murder and manslaughter

A person who "causes" the death of a human being "directly or indirectly, by any means," has committed homicide. Case law holds that any non-trivial act that is a "contributing" (as opposed to a substantial or primary) cause of death "causes" death.[18] Homicide amounts to murder or manslaughter if death is caused by an unlawful act or criminal negligence (discussed separately later). Although the code does not define "unlawful act," case law suggests that it is an intentional act that, "viewed objectively, is likely to subject another person to danger of harm or injury."[19] To justify a conviction of murder, a person who causes death by an unlawful act or criminal negligence must also have had the intention to commit murder — that is, "actual subjective foresight of the likelihood of causing the death coupled with the intention to cause that death."[20-24] Thus, on a strict interpretation of the code, a physician who withdraws a patient's respirator might have committed murder or manslaughter.

Criminal negligence

Section 219 of the code[15] defines criminal negligence as actions or omissions of duty that show "wanton or reckless disregard for the lives or safety of others." Wanton or reckless conduct has been defined by case law as that "which reveals a marked and significant departure from the standard which could be expected of a reasonably prudent person in the circumstances."[25] It is unclear whether the offence is committed merely by engaging in markedly imprudent conduct or whether the conduct must be accompanied by "some degree of awareness or advertence to the threat to the lives or safety of others or alternatively a wilful blindness to that threat."[26-29] As already noted, a criminally negligent act that causes death may amount to murder or manslaughter. As well, the code incorporates an offence of criminal negligence causing death.[30]

Sections 215, 216 and 217 of the code[15] impose duties that, in the breach, may amount to criminal negligence and that have implications for medical practice. Section 215 provides, in part, for the following.

> Everyone is under a legal duty to . . . provide the necessaries of life to a person under his charge if that person
> (i) is unable, by reason of detention, age, illness, insanity or other causes, to withdraw himself from that charge, and
> (ii) is unable to provide himself with the necessaries of life.

So, for example, a physician who withdraws a respirator from a paralysed patient may have breached his or her legal duty to provide the necessaries of life.

Section 216 reads, in part, as follows.

> Everyone who undertakes to administer surgical or medical treatment to another person . . . [is] under a legal duty to have and to use reasonable knowledge, care and skill in so doing.

It is possible that a physician who withdraws or withholds a life-sustaining treatment may be held to have failed to use reasonable knowledge, care or skill in the administration of medical treatment.

Finally, section 217 provides that anyone who undertakes to do an act "is under a legal duty to do it if an omission to do the act is or may be dangerous to life." This section might mean that a physician who has initiated the use of a respirator is under a duty to maintain it so long as his or her patient's life depends on it.

Aiding and abetting suicide

Suicide is no longer a crime in Canada, but some related acts are. Section 241 of the code[16] provides, in part, for the following.

> Everyone who
> (a) counsels a person to commit suicide, or
> (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence.

The meaning of "counsels," "aids" and "abets" in this context is unclear.[31,32] Moreover, the code does not define suicide, although one text says that it is "the causing of death of oneself with the intention of causing death."[33] Neither this definition nor section 241 offers any basis for a principled distinction between aiding and abetting suicide and withholding or withdrawing life-sustaining treatment from a patient.

Consent to the infliction of death

Section 14 of the Criminal Code[17] states a rule that applies to every criminal offence involving the death of a person.

> No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal

responsibility of any person by whom death may be inflicted on the person by whom consent is given.

The civil law allows patients to choose death over treatment and requires physicians to respect such choices. Section 14 of the Criminal Code may prohibit patients from consenting to death and physicians from acting on such consent. Indeed, one writer has commented in reference to this section that "whatever the merits of distinguishing between active and passive euthanasia or between killing and allowing to die, and whatever current medical practices might be, it is clear that all forms of mercy killing could presently result in a homicide conviction."[34] On the face of it section 14 conflicts with the right to refuse treatment.

Mr. Justice Dufour's interpretation of the Criminal Code

The problem that confronted Mr. Justice Dufour in the Nancy B. case was the apparent conflict between the doctrine of informed consent and the criminal law. His task was to find a principled distinction between the consensual withdrawal of life-sustaining treatment and the ambit of some broadly worded provisions of the Criminal Code.

The judge began his consideration of the Criminal Code with some introductory remarks that "put the issue in its proper context."

> What Nancy B. is seeking, relying on the principle of personal autonomy and her right of self-determination, is that the respiratory support treatment being given her cease so that nature may take its course; that she be freed from slavery to a machine as her life depends upon it. In order to do this, as she is unable to do it herself, she needs the help of a third person. Then, it is the disease which will take its natural course.[35]

To these remarks Mr. Justice Dufour appended a quotation from a US judgement that supports the view that Nancy B.'s refusal of treatment was not "an attempt to commit suicide" but, rather, an attempt merely to allow a disease "to take its natural course."[36] So, it appears that if Nancy B.'s respirator were disconnected at her request, then her underlying illness rather than the disconnection of the respirator would cause her death.

Mr. Justice Dufour first considered the criminal negligence provisions of the code. General provisions like section 217 should, he held, be construed in a way that avoids absurd results and strikes an appropriate balance between individual "autonomy" and "larger societal" interests. He implied that it would be absurd and an undue restriction of autonomy if section 217 deprived Nancy B. of her legal right to refuse treatment. Furthermore, the general duty imposed by section 217 must be read in the light of the more specific duties imposed by section 216 and section 45 (governing criminal liability arising from the performance of surgery). Mr. Justice Dufour's reasoning seems to have been that Parliament has imposed specific duties on physicians in the Criminal Code, and it is unreasonable to find additional, unspecified duties in the code's general provisions that conflict with the legal right to refuse unwanted treatment. Thus, section 217 imposes no special duties on physicians beyond those found elsewhere in the code. Moreover, a consensual withdrawal of life-sustaining treatment is a reasonable act that does not breach the duty, imposed by section 216, to use reasonable knowledge, care and skill in administering treatment. Finally, a consensual withdrawal of treatment does not show a wanton and reckless disregard for life, and so it is not criminally negligent.

Mr. Justice Dufour then considered whether the withdrawal of Nancy B.'s respirator would amount to murder, manslaughter or the aiding of suicide. He stated that his review of the criminal negligence provisions "is sufficient to conclude that the person who will have to stop Nancy B.'s respiratory support treatment in order to allow nature to take its course, will not in any manner commit" these crimes. By this, the judge appears to have meant that the provisions of the code covering these offences should be interpreted to avoid absurd results and to respect individual autonomy. To this general interpretation he added an important factual consideration: the withdrawal of Nancy B.'s respirator would allow nature to take its course, but "homicide and suicide are not natural deaths." In essence, the withdrawal of Nancy B.'s respirator was no crime because it did not "cause" her death.

Mr. Justice Dufour's reasoning on the causation of death was patently artificial. Nancy B.'s case concerns the refusal of life-sustaining treatment. When the judge ordered that the respirator be withdrawn at Nancy B.'s request he knew that she would die without it, just as her physician, her family and Nancy B. herself did.[37] Thus, it is difficult to see how the disconnection of the respirator does not fall within the case law definition of "cause" or even of "unlawful act." An example clarifies both the artificiality and the danger of claiming that disconnection of the respirator would not cause death. Imagine a patient similar in every respect to Nancy B. except that she wishes to live, but her physician disconnects her respirator. Surely no one would deny that the patient's death was caused by the disconnection of the respirator.

To criticize as artificial and unsatisfactory the reasoning behind the judgement in the case of Nancy

B. is not to criticize Mr. Justice Dufour but, rather, to begin to comprehend the full magnitude of the problem that he faced. To avoid the code provisions relating to aiding suicide, murder and manslaughter, he had no alternative but to hold that the withdrawal of Nancy B.'s respirator would not cause her death. He could not conclude that her death would be "caused" by the withdrawal of the respirator and that she had consented to death being imposed, because this would have openly contradicted section 14 of the code, which provides that a victim's consent does not affect criminal responsibility for causing death. Nor could he hold that Nancy B.'s death caused by the withdrawal of her respirator was justified by compassion or by respect for her autonomy and self-determination, for these motives do not justify the commission of an otherwise criminal act (i.e., causing death with the intention to do so). Finally, had Mr. Justice Dufour concluded that the relevant provisions of the federal Criminal Code and of Quebec's Civil Code conflicted he would then have had to resolve the politically heated and legally complicated question of which law prevailed over the other.

Mr. Justice Dufour struggled to interpret the Criminal Code in a way that would allow him to decide the case before him fairly and without becoming embroiled in a conflict between federal and provincial laws. However, the marks of the struggle show. The Criminal Code conflicts with contemporary medical practice and the doctrine of informed consent. In individual cases judges may find ways to aid individuals like Nancy B., but such decisions are unlikely to supply health care providers with clear and reasonable guidance in the withdrawal or withholding of life-sustaining treatment.

Amendments to the Criminal Code

A bill was recently introduced into Parliament that would have amended the code to provide for the withholding or withdrawal of life-sustaining treatment. Bill C-203, entitled *An Act to Amend the Criminal Code (Terminally Ill Persons)*, was introduced by a private member, Mr. Robert Wenman. It passed second reading and was referred to a committee for consideration, but it went no further.[38] In part, the proposed amendments would have provided that a health care practitioner commits no offence if she or he

> Does not commence or continue to administer
> (i) surgical or medical treatment to a person who clearly requests that such treatment not be commenced or continued [or]
> (ii) surgical or medical treatment to a person where such treatment is medically useless and not in the best interests of the person, except where the person clearly requests that such treatment be commenced or continued.

These amendments are well intentioned but defective. First, they do not refer to the competence of people who refuse treatment. Second, they embody the vague and unduly restrictive concept of medical futility ("medically useless"). Third, they recognize patients' wishes ("clearly requests") and "best interests" as the sole standards for decision making, thus excluding an important middle standard — an approximation, based on the patient's known beliefs and values, of the patient's own decision ("substituted judgement"). Fourth, they do not make sufficient provision for substitute decision making on behalf of incompetent people. Finally, they forbid physicians to withdraw or withhold treatment that a patient "clearly requests," thus perhaps forcing physicians to choose between the provision of unwarranted treatment and potential criminal sanctions.

We presented amendments to Bill C-203 to the parliamentary committee that had considered it. The rule we proposed for people whose competent wishes regarding treatment are known or who, while competent, have appointed someone to make medical decisions on their behalf was as follows.

> A medical practitioner need not commence or continue to administer surgical or medical treatment to:
> (i) a competent person who clearly requests that such treatment not be commenced or continued; [or]
> (ii) an incompetent person who, while competent,
> (a) clearly requested that such treatment not be commenced or continued, or
> (b) gave another person the authority to make treatment decisions on his or her behalf if that other person clearly requests that such treatment not be commenced or continued.

Subsection (i) provides for competent patients like Nancy B. who make their own decisions to refuse treatment. Subsection (ii)(a) provides for incompetent people who, while competent, made a living will by which they refused a treatment that a physician now wishes to administer. Subsection (ii)(b) provides for incompetent people who, while competent, appointed another person to make treatment decisions on their behalf. Admittedly, subsection (ii) might be criticized as a federal intrusion on provincial law, for it recognizes the validity of advance directives in provinces whose laws do not currently provide for them. However, even in those provinces that do not have statutes recognizing advance directives the common law may already do so. Moreover, our proposal leaves it for provincial

law to settle the question of civil liability arising from reliance on advance directives to withhold or withdraw life-sustaining treatment. In our view any limit that subsection (ii) places on provincial law is wholly justified, because it is simply wrong to impose criminal liability on a physician for honouring an advance directive that requires him or her to withhold or withdraw life-sustaining treatment. Together, subsections (ii) (a) and (ii) (b) cover the two main types of advance directives.[39]

The rule we proposed for people whose competent wishes regarding treatment are unknown and who have not appointed anyone to make decisions on their behalf was as follows.

A medical practitioner need not commence or continue to administer surgical or medical treatment to an incompetent person whose wishes regarding treatment or regarding a substitute decision maker are unknown or unclear:

(i) if the treatment is refused on the person's behalf by another person who has the legal authority to do so;

(ii) (a) if no one with the legal authority to make treatment decisions is available or willing to make treatment decisions, and

(b) if the imposition of treatment would be contrary to values and beliefs that the person was known to have held when competent and would likely still act on if competent to do so;[40] or,

(iii) (a) if no one with the legal authority to make treatment decisions is available or willing to make treatment decisions, and

(b) if the person's own values and beliefs regarding the treatment are unknown or unclear, and

(c) if the treatment is not in the person's best interests.

Subsection (i) provides for substitute decision-makers (e.g., court-appointed guardians) who are not appointed by the person on whose behalf the decision is made. Subsection (ii) applies if there is no available substitute decision-maker but it is possible to make a substituted judgement on the person's behalf; this subsection might, for example, allow a physician to withhold a blood transfusion from a patient who is known to be a devout Jehovah's Witness. Finally, as a last resort subsection (iii) provides for judgements about a patient's best interests. Subsections (ii) and (iii) are also needed in provinces whose laws do not provide for substitute medical decision making. We have also drafted definitions of "competent" and "best interests," which are available on request.

Although the Criminal Code should be amended to incorporate clear and reasonable rules governing the withholding or withdrawal of life-sustaining treatment this is not likely to happen soon. Indeed the matter is hardly urgent, for there appear to be no reported criminal prosecutions of health care practitioners for such acts. Still, in a society in which interest groups do battle under the banners of "right to life" and "right to die" it is realistic to fear that sooner or later some disgruntled person will see a political advantage in laying a criminal charge. However, amendment of the Criminal Code is not the only way to overcome this threat. The law comprises not only the laws on the books but also the policies and practices of those who make decisions about when and how to apply them — coroners who investigate deaths and crown attorneys who prosecute criminal charges. Our proposed rules might serve as guidelines for the exercise of prosecutorial discretion in the laying of charges and in the withdrawal or staying of charges brought by private informants.

An immediate solution to the present gap between medical practice, the law of informed consent and the Criminal Code may be found in the adoption of our guidelines by the provincial attorneys-general.

References

1. *Nancy B. v. Hotel-Dieu de Quebec et al* (1992), 86 DLR (4th) 385 (Que Sup Ct)
2. Arts 18-19.1 CCLC
3. *Nancy B. v. Hotel-Dieu de Quebec et al* (1992), 86 DLR (4th) 390, 392 (Que Sup Ct)
4. *Malette v. Shulman* (1990) 72 OR (2d) 417 (Ont CA)
5. *Fleming v. Reid* (1991), 4 OR (3d) 74
6. *Medical Consent Act*, RSNS 1989, c 279
7. Bill 109, *An Act Respecting Consent to Treatment*, 1st Sess, 35th Leg Ont, 1991
8. Dickens BM: The right to natural death. *McGill Law J* 1981; 26: 847
9. Singer PA, Siegler M: Elective use of life-sustaining treatments. In Stollerman GH (ed): *Advances in Internal Medicine*, vol 36, Year Bk Med, New York, 1991: 57-59
10. *Cruzan v. Director, Missouri Department of Health* (1990), 110 S Ct 2841
11. *Criminal Code*, RSC (1985), c C-34, ss 14, 45, 215-217, 219, 220, 226
12. *Euthanasia, Aiding Suicide and Cessation of Treatment* (working paper 28), Law Reform Commission of Canada, Ottawa, 1982
13. *Euthanasia, Aiding Suicide and Cessation of Treatment* (report 20), Law Reform Commission of Canada, Ottawa, 1983
14. *Criminal Code*, RSC (1985), c C-34, ss 222-240
15. Ibid: ss 215-217, 219
16. Ibid: s 241
17. Ibid: s 14
18. *Smithers v. The Queen* (1977), 34 CCC (2d) 427 (SCC)
19. *R. v. Cole* (1981), 64 CCC (2d) 119 (Ont CA) at 127
20. *R. v. Vaillancourt* [1987] 2 SCR 636 at 645 interpreting *Criminal Code*, RSC (1985), c C-34, s 229 (a) (i)
21. Mewett AW, Manning M: *Criminal Law*, 2nd ed, Butterworth, London, 1985: 534-535
22. Stuart D: *Canadian Criminal Law*, 2nd ed, Carswell, Toronto, 1987: 117-156
23. *Criminal Code*, RSC (1985), c C-34, s 229 (a) (ii)
24. *R. v. Martineau* [1990] 2 SCR 633
25. *R. v. Tutton* [1989] 1 SCR 1392 (SCC) at 1431
26. Ibid at 1407
27. *Anderson v. R.* [1990] 1 SCR 264

28. Greenspan EL (ed): *Martin's Annual Criminal Code*, Canada Law Book, Aurora, Ont, 1992: 320-321
29. Stuart D: *Canadian Criminal Law*, 2nd ed, Carswell, Toronto, 1987: 183-203
30. *Criminal Code*, RSC (1985), c C-34, s 220
31. Greenspan EL (ed): *Martin's Annual Criminal Code*, Canada Law Book, Aurora, Ont, 1992: 348
32. Smith JC, Hogan B: *Criminal Law*, 6th ed, Butterworth, London, 1988: 360-361
33. Mewett AW, Manning M: *Criminal Law*, 2nd ed, Butterworth, London, 1985: 561
34. Stuart D: *Canadian Criminal Law*, 2nd ed, Carswell, Toronto, 1987: 473
35. *Nancy B. v. Hotel-Dieu de Quebec et al* (1992), 86 DLR (4th) 385 (Que Sup Ct) at 392
36. *In The Matter of Clair C. Conroy*, 486 A 2d 1209 (NJ 1985) at 1224 cited in Nancy B. at 392
37. *Nancy B. v. Hotel-Dieu de Quebec et al* (1992), 86 DLR (4th) 385 (Que Sup Ct) at 387-388
38. Bill C-203, *An Act to Amend the Criminal Code (Terminally Ill Persons)*, 3d Sess, 34th Parl, 1991
39. Advance Directives Seminar Group, Centre for Bioethics, University of Toronto: Advance directives: Are they an advance? *Can Med Assoc J* 1992; 146: 127-134
40. Bill 109, *An Act Respecting Consent to Treatment*, 1st Sess, 35th Leg Ont, 1991, s 14 (2) (a)

Conferences

continued from page 623

Sept. 15, 22 and 29 and Oct. 6 and 13, 1992: Beyond Survival — Getting in Touch: Working with our Anger, Fear and Sorrow (part 3 of 9 in the Women Healing from Childhood Trauma Workshop Series)
Feminist Therapies Services, 344 Dupont St., Toronto
Registration coordinator, Community Resources and Initiatives, 106-344 Dupont St., Toronto, ON M5R 1V9; (416) 924-8998, fax (416) 924-8352

Sept. 18, 1992: Breastfeeding Seminar for Health Professionals (sponsored by the La Leche League of Quebec and Eastern Ontario)
Ottawa Civic Hospital
Agnes Vargha, conference coordinator, 25 Bernier Terr., Kanata, ON K2L 2V1; (613) 592-2379

Sept. 19, 1992: Psychiatric Drugs in Primary Care — Recent Innovations: Practical Approaches, Interactive Learning
Estates of Sunnybrook (Vaughan House), Sunnybrook Health Science Centre, Toronto
Cindy Stolarchuk, conference coordinator, Sunnybrook Health Science Centre, (416) 480-6100, ext. 5904

Du 30 sept. au 3 oct. 1992 : L'Association canadienne pour la prévention du suicide (ACPS) Congrès 1992 — Le suicide et la famille
Delta Bessborough Hotel, Saskatoon
Congrès 1992 de la ACPS, 1410-12th St. W, Saskatoon, SK S7M 0Z4; (306) 664-4525, fax (306) 664-1974

Sept. 30-Oct. 3, 1992: Canadian Association for Suicide Prevention (CASP) '92 Conference — Suicide and the Family
Delta Bessborough Hotel, Saskatoon
CASP Conference '92, 1410-20th St. W, Saskatoon, SK S7M 0Z4; (306) 664-4525, fax (306) 664-1974

Oct. 2-4, 1992: Beyond Survival — Sexual Expression and Early Childhood Trauma (part 4 of 9 in the Women Healing from Childhood Trauma Workshop Series)
Feminist Therapies Services, 344 Dupont St., Toronto
Registration coordinator, Community Resources and Initiatives, 106-344 Dupont St., Toronto, ON M5R 1V9; (416) 924-8998, fax (416) 924-8352

Oct. 5-6, 1992: 11th International Congress on Objective Assessment in Rehabilitation Medicine
Hotel Sheraton Centre, Montreal
Centre de formation en réadaptation du Québec, 6300 Darlington Ave., Montreal, PQ H3S 2J4; (514) 340-2089, fax (514) 340-2149

Oct. 5-7, 1992: Inaugural Congress of the International Association of Bioethics (organized by the Health Council of the Netherlands)
Royal Tropical Institute, Amsterdam
Congress Secretariat, c/o Health Council, PO Box 90517, 2509 LM The Hague, the Netherlands

Oct. 6, 1992: WINs of Change: Viewing the Stresses of Change as Opportunities
Ottawa
Guest speaker: Dr. Peter Hanson
Agnes Friesen, Department of Rehabilitation Services, Ottawa Civic Hospital, 1053 Carling Ave., Ottawa, ON K1Y 4E9; (613) 761-4722

Oct. 7, 14, 21 and 28 and Nov. 4, 1992: Beyond Survival — Fear Management for Ritual Abuse Survivors (part 2 of 9 in the Women Healing from Childhood Trauma Workshop Series [other dates available])
Feminist Therapies Services, 344 Dupont St., Toronto
Registration coordinator, Community Resources and Initiatives, 106-344 Dupont St., Toronto, ON M5R 1V9; (416) 924-8998, fax (416) 924-8352

Oct. 8, 1992: How Does Health Technology Assessment Influence Health Policy Formation? (first in a series of regional symposia)
Westin Hotel, Ottawa
Janet Comis, project manager, Canadian Coordinating Office for Health Technology Assessment, 110-955 Green Valley Cr., Ottawa, ON K2C 3V4; (613) 226-2553, fax (613) 226-5392

Oct. 11-14, 1992: International Health Policy and Management Institute 9th Annual Conference on International Health Policy
Budapest
Darwin W. Schlag, Jr., Arthur Andersen & Company, 1010 Market St., St. Louis, MO 63101; (314) 425-9228, fax (314) 621-1956

continued on page 683

For prescribing information see page 742 →